UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

DAYTRANA(methylphenidate)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Available for ages 6 through 18
- Documentation of physical inability to swallow.

OR

- Documentation that patient is currently on a combination of two stimulants or stimulant(s) and Strattera or that patient is on two different strengths of the same ADD/ADHD medication - Daytrana must be a more cost-effective therapy.
- Prior authorization will not be granted if the client has had an allergic reaction on other methylphenidate formulations.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated Letter of Medical Necessity.

12/29/6